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Incivility in Nursing Education: An Intervention

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Incivility in Nursing Education: An Intervention

by

Ruthanne Palumbo

A capstone project submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the degree of
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Abstract

Incivility in nursing education is an unfortunate phenomenon affecting nursing students in all aspects of their educational experience. Students and their instructors are often ill equipped to deal with academic incivility and their lack of ability to handle such behaviors has proven detrimental to the future of the nursing profession. Nursing instructors need tools to help educate nursing students on how to recognize uncivil behaviors within themselves as well as others and ways to combat it. This Capstone Project addressed these aspects of academic incivility and implemented an e-learning module that was developed to educate students on incivility. The data was collected through a pre-test, post-test model with resulting statistical analysis using the McNemar's test. Results showed the nursing students obtained increased self-efficacy in regards to their ability to define, detect, and combat academic incivility after viewing the e-learning module. In conclusion, the successful implementation of the e-learning module provides further incentive for schools of nursing to consider implementing incivility education in their curriculums.

Keywords: incivility: prevention, identification, interventions, reducing, recognizing, new graduate nurses, nursing students, education, social learning theory, role modeling

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Problem Recognition

Identified Need

Increasingly, nurse educators and nursing students are challenged to deal with unprofessional behaviors such as academic dishonesty, bullying, and incivility in the classroom and clinical settings. The effects of incivility alone are well documented and are not limited to the halls of nursing school and often continue well into the graduate nurses' work environments. The research regarding incivility is unmistakably associated with high attrition rates, errors, accidents, poor performance, absenteeism, decreased commitment, and low job satisfaction (Ceravolo, Schwartz, Foltz-Ramos, & Castner, 2012; Smith, Andrusyszyn, & Spence-Laschinger, 2010).

Although incivility directed at nurse educators is reported, research suggests nursing students and new graduate nurses transitioning into practice are the most vulnerable and likely to fall prey in environments where uncivil behaviors have become widely accepted and even ritualistic in nature. With evidence of incivility beginning in nursing school, it is deeply concerning that education on its presence and prevention has not been mandated at the academic level (Young, 2011). There appears to be an unlimited amount of data available regarding its occurrences, nurse experiences, contributing factors, and root causes. Unfortunately, the limitations in the literature are in its eradication.

Using current evidenced-based nursing and other professional practice guidelines this Capstone project will determine what the most effective way for nurses in leadership roles (e.g. nurse educators, nurse mentors) to educate themselves and each other on how

to uphold professional standards and breed an environment of civility for the new generation of nurses.

Problem Statement

Can the implementation of an incivility intervention competencies (IIC) module increase self-efficacy in the demonstration of civil behaviors among nursing students?

Introduction

Disruptive behaviors are known to be counterproductive and even harmful in healthcare environments. These behaviors are often directly and indirectly related to poor employee performance, medical errors, and subsequent patient harm (Burgess & Patton Curry, 2014; Longo, 2010). Nursing literature cites many instances in which disruptive behaviors and poor communication skills have created hostile work environments negatively impacting patient safety and quality care (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). In 2008, The Joint Commission (TJC) released a sentinel event (SE) alert identifying failed communication as the “root cause” in one-third of all reported adverse patient events or near misses (Burgess & Patton Curry, 2014; Institute of Medicine, 2011; TJC, 2008).

Nurse educators being at the forefront of a nurse’s career should be expected to role model civility toward each other, toward the students, and the interdisciplinary team. Research of the literature indicates nursing students and new graduate nurses transitioning into practice are the most vulnerable, and with evidence of incivility beginning in nursing school it is deeply concerning that education on its presence and prevention has not been mandated at the academic level. This Capstone project explored

incivility, its causes, how to recognize and define it, ways to combat and potentially prevent it, and the need for interventions.

Incivility

The incidence and prevalence of incivility has become widespread in our nation's many health care settings. Incivility in nursing is well documented and unmistakably associated with high rates of workplace attrition, poor performance, absenteeism, employee accidents, decreased commitment, and low job satisfaction rates; as well as medical errors (Ceravolo et al. 2012; Smith et al., 2010). According to Coursey, Rodriguez, Dieckmann and Austin (2013), 93% of the nurses surveyed reported witnessing uncivil behaviors and 85% reported personally being the victim themselves. Likewise, student and new graduate nurses in earlier studies indicated they have personally witnessed and experienced incivility perpetrated by their instructors, nurses in the clinical setting, preceptors, and even their peers. (Clark & Springer, 2010; Guidroz, Burnfield-Geimer, Clark, Schwetschenau, & Jex, 2010; Smith et al., 2010).

As a profession, nursing is characterized by its compassionate and caring nature toward patients. Perhaps this is what makes reports of incivility towards other nurses, nursing students, or new graduate nurses so disturbing. With this practice one must wonder if health professionals are indirectly inflicting patient harm or directly hindering the patient safety movement by "eating our young" and future nurses. Unfortunately, the amount of research addressing incivility directed toward student nurses in practice settings is alarmingly scarce. However, there are several studies examined in the literature review such as Luparell's 2008 report calling for an end to incivility in nursing education and Altmiller's 2012 study on student perceptions of incivility in nursing

school. Equally disappointing is the silence from legislative or regulatory fronts concerning uncivil behaviors inflicted on novice nurses transitioning into practice. Although the Occupational Safety and Health Act (OSHA) of 1970 was enacted to address workplace abuse and violence, its influence has been limited to issuing recommendations and encouraging voluntary participation practice guideline implementation (Mason, Leavitt, & Chaffee, 2014).

It is imperative for educators to understand the impact of a hostile workplace on the students' ability to learn and actually provide safe and effective care. Thereby, the ultimate aim of the Capstone project is to prompt nurse educators to introduce incivility intervention competencies (IIC) in their programs of study. The Capstone project culminated with a sample of an IIC curriculum module based on the Institute of Medicine (IOM, 2001; 2011); as well as the Interprofessional Education Collaborative (2011) report. Evidence-based programs that educate faculty and prepare student nurses to combat incivility were examined as well.

Pervasive Nature of the Problem

When considering the pervasive nature of workplace abuse, bullying incivility, and violence, it is distressing to discover individuals in all sectors of the nursing profession are vulnerable. Unfortunately, some individuals will become perpetrators, while others become their victims. Studies indicated nurse educators or preceptors, if left unrestrained, will later adopt the same practice of incivility they may have witnessed or even experienced (Croft & Cash, 2012). Equally disconcerting are reports by nurse educators of increasing student incivility, such as aggressive, intimidating, blaming, and shunning behaviors (Clark & Springer, 2010; Robertson, 2012). The cycle continues as

clinical nurses, preceptors, and nurse educators report uncivil acts committed by supervisors, physicians, patients, and fellow nurses (Guidroz et al., 2010; Smith et al., 2010). However, as previously mentioned the nursing literature indicated nursing students and new graduate nurses transitioning into practice are the most susceptible and likely to become victims of incivility (D'ambra & Andrews, 2014; Magnavita & Heponiemi, 2011).

Definition of Terms: Incivility, Workplace Violence, and Abuse

The term incivility in the literature is often used concurrently with several other related terms, and therefore will be further defined along with those terms in this section. The National Institute for Occupational Safety and Health (NIOSH) 2004 originally defined incivility as workplace violence and abuse and has been redefined to include disruptive behaviors not limited to violent acts. They are summative concepts used by researchers to depict a level of hostility or incivility related to communicated threats, disruptive conduct, or even explosive behaviors while individuals are on duty. NIOSH's (2004) further expanded the definition to include latent or abusive behaviors associated with bullying, social isolation, humiliation, and slander.

Incivility has been identified as the most comprehensive descriptor for the disruptive behaviors directly or indirectly related to medical errors and subsequent patient harm (Spence-Laschinger, 2014). However, it wasn't until the release of SE Alert #40 by TJC in 2008, the term incivility was used to encompass both lateral and horizontal violence or any other negative behavior levied on providers in health care (Burgess & Patton Curry, 2014; TJC, 2008).

Incivility is a commonly used social term even defined in Webster's Dictionary (2014) as "the quality or condition of being uncivil; discourteous behavior or treatment, an uncivil act, without good manners, unmannerly, rude impolite, and discourteous" (Merriam-Webster Online Dictionary, 2014). Specifically included are behaviors such as actual physical threats, flagrant defiance, impatient, condescending tones, verbal eruptions, or the passivity associated with blatantly ignoring requests. According to TJC (2008), disruptive behaviors were characterized as often subliminal, overt, or covert actions that undermine patient safety. Since incivility encompasses a cadre of negative and intimidating responses or actions, it may occur more subtly than other forms of lateral and horizontal violence or abuse. The concealed nature of incivility makes it virtually undetectable in complex health care settings, thereby making it a great threat to patient safety. Additionally, not only seen as a threat to safe and effective patient centered care, disruptive and intimidating behaviors have been deemed major contributors to work strain, poor staff morale, and high staff turnover rates. Therefore from this point forward in the article the term incivility will be used as an all-encompassing term.

In educational settings academic incivility is defined as any speech or behavior that negatively affects the wellbeing of students or faculty members, weakens professional relationships, and hinders the teaching-learning process (Clark & Davis-Kenaley, 2011; Marchiondo, Marchiondo, & Lasiter, 2009).

Summary/Gaps in Practice

Over the past 20 years there has been numerous reports regarding the incidence and prevalence of incivility in nursing and more specifically nursing education and new

graduate nurses (D'ambra,& Andrews, 2014; Magnavita & Heponiemi, 2011). Lacking are realistic and readily available solutions and interventions. Equally absent from the literature are research studies regarding incivility interventions and best practice guidelines. It is unrealistic to think everyone can or will get along, it is however, realistic to think everyone should be expected to act with civility toward colleagues/co-workers and those they serve to educate. Educators and nurse leaders need to provide nursing students with incivility interventions to combat this widespread phenomenon.

Discussion

A compelling report issued by the National League of Nursing (NLN, 2005) calling for transformational educational practices should serve as the impetus for schools of nursing to embrace incivility interventions. Implementing recommendations issued by the NLN, IOM as well as other nursing experts could serve to circumvent the negative impact of hostile work environments (NLN, 2005; IOM, 2011). Educators should be motivated by the groundbreaking reports from the IOM (2001; 2011) calling for healthy work environments conducive to interprofessional communication and collaboration. This acknowledged the need to better prepare students and graduates before graduating them into complicated and potentially hostile practice settings (Agency for Healthcare Research and Quality, 2013; Institute of Medicine (IOM), 2001) and expectantly calling for the incorporation of an IIC module into their nursing curricula.

With new graduate nurses leaving their first jobs at disproportionate numbers and others leaving the profession all together (Fowler, 2011) the time to act is now. By implementing interventions, like the suggested IIC module, nurse educators should hold their students, themselves, and their clinical agencies nurses to the American Nurses'

Association's (ANA) Code of Ethics and stop allowing this unethical behavior to continue. The safety of the patients, the wellbeing of new nurses, and the integrity of the profession are all at stake.

Needs Assessment

Review of Literature

The scarcity of interventions addressing the impact of incivility and the salient nature of abusive behaviors on the student and novice nurse's wellbeing and their ability to provide safe and effective care is disheartening. A literature search using MEDLINE-EBSCOhost and CINAHL databases yielded research studies linking the effect of incivility on patient safety, impact on nursing education, and student and novice nurses transitioning into practice. Sadly, no research studies were found regarding the implementation of interventions to combat incivility in the academic setting for nursing students. There were however, several articles offering suggested incivility interventions for nurses in a variety of academic and acute care settings.

Transition to Practice

Only one study retrieved examined the transition into practice issues for new graduate nurses in hostile work environments. In the integrated literature review, D'ambra & Andrews (2014) reviewed 16 relevant articles, analyzing a total of 13,577 new graduate nurses. The aim of the review was to evaluate the influence of incivility on the new graduate nurse transitioning into practice. Reports of incivility from the new graduates included; feeling undervalued, emotional neglect, lack of supervision, blocking of learning opportunities, and fear of repercussion to speaking out. It was disturbing to see that in the 16 studies reviewed there appeared to be a ubiquitous practice of

assimilating new nurses into uncivil practices. Once again demonstrating a tolerance for the perpetual cycle of bullying, violence, and abuse to continue. This article is significant because the researchers concluded that incivility contributed to the novice nurses' low job satisfaction and high turnover rates. Limitations to the study included a lack of research that directly assessed interventions intended to reduce incivility (D'ambra & Andrews, 2014).

Impact on Patient Safety

Over the years it appears health care professionals have mastered the art of "eating their young". By creating hostile environments or failing to protect student and novice nurses entering the profession from acts of incivility while they learn the trade, the health care industry has endorsed the continuation of such disruptive behaviors.

Historically seen as a rite of passage or an opportunity to increase the hardiness of student or novice providers, the age-old tradition of intimidating new professionals have been correlated with grave consequence. Although it undermines patient safety, many health care locales have become so indoctrinated with the portrayal of incivility that has become the norm (D'ambra, & Andrews, 2014; Magnavita & Heponiemi, 2011).

Magnavita and Hemponiemi (2011) conducted a retrospective survey in three university schools of nursing. Three hundred and forty six nursing students and an additional 275 hospital nurses filled out a questionnaire to compare the characteristics and effects of violence to assess the phenomenon and take preventive action. Forty-three percent of hospital nurses and 34% of nursing students reported being the victim of verbal or physical abuse. Participants said the abuse originated from other students, teachers, doctors, supervisors, and patients or the patient's relatives. Nurses reported

they were mostly assaulted or harassed by their patients and/or their patients' relatives, whereas student nurses reported the abuse came mostly from colleagues, staff, and others including their teachers. Unfortunately no specific interventions were offered only that preventative action is urgently needed to control these types of interactions and that both hospital nurses and nursing students would benefit from multileveled programs aimed at violence prevention (Magnavita & Hemponiemi, 2011).

A classic study frequently referenced for its findings regarding nursing staffing and skill-mix published in 2002 by Aiken, Clarke, Sloane, Sochalski and Sibley provided an indirect link between horizontal bullying, retention and job satisfaction. Researchers used a multisite cross-sectional survey, 10,319 nurses working on medical-surgical units in 303 hospitals across in the United States, Canada, England, and Scotland. In the study, researchers examined nurse staffing, organizational support, and the subsequent effects these areas have on issues like job dissatisfaction, nurse burnout, and the quality of patient care. The article presents one weakness, additional research examining the impact of incivility in hostile work environments on the novice nurses' ability to provide safe and effective quality care is inadequate (Aiken et al., 2002).

Identified as the root cause of adverse patient outcomes, the culprit for escalating health care costs and catalyst for poor patient experiences, incivility's impacts on quality care, and patient safety is now receiving national attention (Burgess & Patton Curry, 2014; Lachman, 2009; 2014; TJC, 2008). A retrospective survey study with over 2,095 hospital providers (n = 1,565 nurses and n = 354 pharmacists) conducted by the Institute of Safe Medication Practices (ISMP) in 2004, found a correlation between patient safety and intimidation that results in poor communication or collaboration. This early study by

the ISMP highlighted the negative impact that intimidation can have on patient safety. From the study, nearly 150 individuals (7%) reported their involvement in a medication error in the previous 12 months as a direct result from the effects of intimidation.

Whereas a staggering 45% reported their superimposed fearfulness of retaliation resulted in their failure to seek medication order clarifications, which was the primary cause of the medical error. This bears asking the question, how many students have failed to seek clarifications due to feelings of intimidation and incivility displayed by staff nurses' and nurse educators.

Impact in Nursing Education

Amplified clearly in the literature is the fact that incivility isn't going to just go away. The findings regarding the prevalence and impact of incivility on student and new graduate nurses is particularly striking. In two front-line studies, students and new graduate nurses confirmed the impact of incivility is more devastating than imagined. Fowler (2011), when serving as the director of students in the school of nursing at the University of South Carolina, conducted surveys and found 90% of both student and new graduate nurses witnessed uncivil behaviors; while 83% identified themselves as victims of such abuse. Multiple groups of 30 nursing students and 900 nurses were surveyed. The students reported although abrasive communications or disruptive interactions were concerning, they weren't the most influential. It was the more covert behaviors such as eye rolling, name-calling, threats, innuendos, and other negative gestures that seem to have the most detrimental effect (Fowler, 2011).

Luparell (2011) and Smith et al. (2010) found similar student nurses reports of uncivil behaviors including feeling unwelcome or ignored, being belittled or humiliated

by faculty and staff nurses, feeling undervalued, and having opportunities blocked by staff nurses. Luparell's review of literature conveyed nursing student and faculty perceptions of incivility and the effects it had on them emotionally and physically. Both groups claimed disengagement, decreased productivity, diminished trust in leadership, lost sleep, and lost confidence (Luparell, 2011). Even more alarming was survey results indicating 60% of new graduate nurses reported leaving their first jobs due to uncivil behaviors directed at them; while another 20% reported leaving the profession altogether (Fowler, 2011; Smith et al., 2010).

Smith et al. (2010) fueled by reports of high attrition conducted a predictive non-experimental design study to examine the impact of structural empowerment, psychological empowerment, and workplace incivility on effective commitment of new graduate nurses. The researchers used the following assembled scales and questionnaires to compile their data for analysis; The Workplace Incivility Scale developed by Cortina, Magley, Williams & Langhout (2001); The Psychological Empowerment Questionnaire developed by Spreitzer (1995); and The Affective Commitment Scale developed by Meyer, Allen, and Smith (1993). In an attempt to understand the factors that influence new graduates' sense of organizational commitment, 117 new graduates participated in the study, and results showed that high rates of incivility contributed to low commitment to the organization. It further indicated that specific strategies to combat incivility, such as increased psychological empowerment, were needed to increase commitment and increase retention of new graduate nurses.

Altmiller (2012) conducted an exploratory study that garnered nine themes identified as student perceptions of experiences of incivility specifically in the academic

setting. The sample included 24 undergraduate junior and senior nursing students from four separate universities in the United States. The study compared unprofessional behaviors, poor communication techniques, power gradient, inequality, and loss of control over ones' world, stressful clinical environment, authority failure, difficult peer behaviors, and student views of faculty perceptions. The participants were divided into four focus groups and were asked questions developed by the researchers from their literature review. The sessions were audiotaped and a content analysis was conducted on the data to examine for recurrent themes.

The study then compared their results of student perceptions of incivility to previously published information regarding faculty perceptions of the same. The research revealed that both students and faculty perceived and experienced incivility similarly and expressed concerns of increasing incidence, however, students further revealed faculty behaviors that fueled and reportedly even justified uncivil acts by students (Altmiller, 2012).

Reportedly, both students and faculty saw unprofessional behaviors in the clinical environment such as staff denying assistance, failure to provide direction, or verbalizing intolerance as uncivil behaviors. Another behavior viewed by both students and the faculty as uncivil was poor communication techniques. However separately, students reported they felt disrespected by faculty when they perceived "being put down" by faculty in the clinical setting. Another separate report of incivility by the students was an unequal power gradient, specifically claiming they feared failure based on clinical evaluation, which was seen as a more subjective process than the objective classroom evaluations. Students further reported a loss of control over ones world, stressful clinical

environments, and inequality as the main issues with incivility they faced in nursing school. (Altmiller, 2012).

Some of the newest research on incivility in nursing education addresses the possibility of generational differences fueling the uncivil behaviors in academia. Research suggested that individuals who believe that their values differ from others within their workgroup are more likely to have a poor attitude; are less helpful, less involved, and less accepting of others; they are more dissatisfied with their colleagues; are more likely to leave their jobs; and may experience burnout (Wolff, Ratner, Robinson, Oliffe, & Hall, 2010). Historically, the nursing workforce has been fairly homogenous, it has however, become more diverse in recent years, especially in terms of nurses ages, education, ethnicity/race, and work values (Wolff et al., 2010). Despite the changing landscape of the attributes of the nursing workforce, there is a lack of research that has critically examined the consequences of the increasing diversification.

Leiter, Price, & Laschinger (2010), conducted an analysis of variance using a questionnaire compiled of the following scales; The CREW Civility Scale developed by Meterko, Osatuke, Mohr, Warren, & Dyrenforth, (2007); The Maslach Burnout Inventory-General Scale developed by Shaufeli, Letier, Mashlach, & Jackson (1996); The Workplace Incivility Scale developed by Cortina, Magley, Williams & Day Langhout (2001) and a modified version of the Turnover Intentions developed by Kelloway, Gottlieb, & Barham (1999), to determine the generational differences in distress, attitudes and incivility among nurses. The sample was taken from two district hospitals in Canada and consisted of Generation X nurses (n=338) and Baby Boomer nurses (n=139). The objective was to test whether Generation X nurses reported more

negative social environments at work than did Baby Boomer nurses. They found negative quality of social encounters at work contributes to a nurse's experience' of distress and suggest conflicts of values with the dominant culture of their workplaces. For example turnover rates are more strongly correlated to supervisor incivility than to coworker incivility. Generation X nurses' experienced higher rates of incivility in the workplace than did their counterparts and reported higher levels of distress. They concluded that proactive initiatives such as anti-bullying policies and promotion of positive work environments to enhance the quality of collegiality could contribute to retention strategies and that building collegiality across generations can be especially useful (Leiter et al., 2010).

Considering the aforementioned detrimental outcomes of incivility, it is imperative that nurse educators take action. Academic nursing institutions should seriously consider implementing a policy to educate their faculty and students on incivility as well as offer conflict resolution and assertiveness trainings. This is the impetus behind the Capstone project and the need for the development of an incivility intervention competencies (IIC) module.

Incivility Interventions

The research reviewed has clearly identified incivility as a vast and deleterious issue in nursing and more specifically nursing education. Unfortunately the focus in the literature to this point seems to be on its existence and the consequences of incivility in healthcare. Glaringly absent from the research however, is ready-made interventions that nurse educators can implement to combat incivility within academic institutions. Nurse leaders not only need to develop interventions but provide the critically needed research

regarding their implementation, use, and outcomes. Without this nurses are left in limbo regarding best practices on combating incivility.

What is suggested by researchers, albeit vaguely and frequently in the conclusion section of their research papers, is the need for proper recognition, communication strategies, mentoring and modeling behaviors by the faculty, and a zero tolerance policy with proper and consistent follow-up (Clark & Springer, 2010; Marchiondo et al. 2009; Guidroz et al., 2010; Khadjehturian, 2012).

Recognition, as suggested, is a key component of combating incivility; one must have the ability to recognize the uncivil behaviors within the people they come in contact with as well as recognize these behaviors within themselves (Khadjehturian, 2012). This can be particularly difficult when most of the questions adapted for incivility scales such as the Workplace Incivility Scale developed by Cortina et al. (2001) and the Nursing Incivility Scale (NIS) developed by Guidroz et al. (2010) are focused on whether or not the person questioned has been the victim, or if the person being questioned has witnessed others as a victim but they are not questioned on whether they have been the perpetrators of incivility themselves. It appears that when polled, many, if not most respondents can identify with being a victim of incivility, what appears to be a barrier to its irradiation is the perpetrators recognition of their actions as being uncivil.

Marchiondo et al. (2009) claims for both faculty and students the cause of incivility is typically not clear-cut. They further explain that incivility may be unintentional, the result of the perpetrators inability to know the consequences of their actions, while claiming other acts of incivility can be a conscious desire to cause harm to their target or targets (Marchiondo et al., 2009). Again, while a person can at times be

both a victim and a perpetrator of incivility, it is equally necessary for a person to identify when they, themselves are being uncivil. The IIC module will clearly define incivility and what student and faculty expectations are.

A second recommendation in the research is for communication strategies to be developed based on the results from implementing a workplace incivility survey versus actual proposed communication techniques. What was suggested was active listening, asking for clarification, relaying uncivil behavior to managers and supervisors, encouraging freedom of expression, and being a mediator when appropriate (Khajehpourian, 2012). Although poor communication can be the very cause of conflict Trossman (2011) reports that nurses in general avoid conflict and often create work-a-rounds so they do not have to engage in conflict and difficult conversations. The American Nurses Association (ANA) offers a conflict engagement course aimed at conflict engagement and resolution (ANA, 2011). However, it appears to be an on-site training session versus a free and available tool for use. Further research outside of nursing is needed to find effective communication techniques and strategies for the development of an incivility intervention module.

Mentoring and role modeling is an imperative part of nursing education and another proposed intervention for combating incivility, making it all the more disheartening to read reports on faculty to student incivility. There is a clear lack of focus on the role of faculty incivility in the literature, attributing this to embarrassment, reluctance to reflect on their behavior, or out-right denial on their part (Clark & Springer, 2007; Marchiondo et al. 2009). Nevertheless, its existence is reported and must be dealt with. Faculty incivility toward students is described as exerting their position,

superiority, arrogance, threatening to dismiss or fail a student, making unannounced changes to a calendar, are all examples of uncivil behaviors (Clark & Springer, 2010). Additional classroom specific behaviors such as being tardy, unprepared for class, and talking too fast are also reported by students as uncivil behaviors exhibited by faculty (Luparell, 2008). Research suggested role-modeling behaviors such as creating cultures of mutual respect and emotional safety, freedom of expression, and role modeling crucial behaviors and engagement techniques (Clark & Springer, 2010). Marchiondo et al. (2009), advised that incivility ignored is incivility condoned and nurse educators should be not be condoning uncivil behavior from others as well as themselves.

With efforts to correct incivility within education institutions, one must not forget to foster relationships among faculty as well. Shanta and Eliason (2013) remarked that students are aware of the tone and the way in which faculty members communicate with one another, and about one another in the student's presence. Therefore promoting collegiality is essential in order to role model civility (Shanta & Eliason, 2013). Caza and Cortina (2007) reported that unresolved incivility in nursing education could interfere with learning and safe clinical performance. Clark and Springer (2007) further attest that incivility on college campuses jeopardizes the welfare of all members of the academy.

With the 2008 release of The Joint Commission's (TJC) sentinel event (SE) alert many institutions have already adopted a zero-tolerance policy for incivility; it appears from the literature however, that it is being underutilized. With increasing reports of incivility it seems that it is either underreported to supervision or isn't effectively being managed. Either way, institutions should consider screening for incivility, promptly and

fairly address any reports of its presence, and implement interventions to combat its effects.

Lastly, student incivility toward faculty can potentially be addressed with all of the aforementioned techniques. Student incivility toward faculty has been defined as tardiness, disruptive, inattentive, challenging faculty, dominating class, side conversations, and cell phone use (Clark & Springer, 2007; Luparell, 2008; Luparell, 2011; Shanta & Eliason, 2013). Faculty also reported being yelled at in the classroom and clinical settings, being pushed, threatened, having belongings vandalized, stalked, and have received death threats (Luparell, 2008). With the development of the IIC module, video scenarios can be created to showcase uncivil encounters and perpetrate suggestions for student nurses to combat incivility.

Population/Community

The identified population is currently enrolled, newly admitted, and second level associate degree nursing students at a community college in southeastern North Carolina.

Sponsors and Stakeholders

Currently enrolled nursing students and faculty. Long term: Areas the student may eventually be employed.

Nursing profession.

SWOT Analysis

Strengths

- Access to target population.
- Willingness/eagerness of colleagues to help and be involved.
- Enthusiasm of target population regarding the project.

- Potential to end or lessen incivility in nursing school.

Weaknesses

- Potential to create conflict due to sensitivity of subject.
- Potential lack of nursing student trust of faculty provided information.
- Current conflict resolution material (encompasses incivility) embedded into ADN curriculum within the leadership and management content, e-Learning module may compete with time allotted for this material.

Opportunities

- Potential to end or lesson incivility during interactions outside of nursing school.
- To provide students with interventions to combat future incivility within their practice.

Threats

- Finding and mastering the appropriate e-learning software.
- Cost of e-Learning software.

Available Resources

- Site to implement: community college in southeastern North Carolina.
- Access to target population.
- Research conducted regarding elements to be included in the incivility competency intervention, verbal permission to use/access the community college's technology resources.

- Availability of equipment and personnel to assist in the development of audio/visual intervention at the implementation site.

Team Selection

- Classroom and Clinical ADN Nursing Instructor for 2nd level students.
- Classroom and Clinical ADN Nursing Instructor for 1st & 2nd level students and 2nd level Coordinator.

Cost/Benefit Analysis

Due to the educational nature of the project a cost benefit would be difficult to attach to outcomes. There is a possibility that future studies could be done to see if there is a correlation between the implementation of an incivility intervention and retention.

Retention of students can be directly related to profits in tuition for colleges.

There will be no cost to the college as far as lost time and/or wages, all Capstone project work, meetings, supplies, software etc. will be accrued and completed outside of the implementation site.

Scope of the Project

- This Capstone project will not add to research previously conducted regarding the presence of incivility in nursing education.
- This Capstone project will contribute to gaps in practice regarding available evidence-based practice suggestions for incivility interventions.
- This Capstone project will develop and implement an incivility competency module and present it to newly admitted first and second level associate degree nursing students.

Goals, Objectives, and Mission Statement

Goals

1. To improve civility in nursing education.
2. To educate nursing students on incivility; how to recognize it from others as well as themselves and provide them with tools to define, detect, and combat it.
3. To develop an educational module to combat incivility in nursing education: develop and implement incivility intervention competencies (IIC).
4. To measure student's self-efficacy regarding their ability to define, detect and combat incivility.

Process/Outcome Objectives

1. Provide nursing students with a clear definition of academic incivility upon entrance of nursing program.
2. Provide nursing students with clear expectations of civil behavior and expectations (policy manual, syllabi) upon entrance to nursing school.
3. Develop and implement an incivility intervention competency (IIC) e-learning module to be presented to nursing students upon entrance to nursing school, using audio and visual technology to define incivility and provide evidence based best practice interventions to combat it.
4. Increase nursing student's self-efficacy regarding their ability to define, detect and combat incivility.

Mission Statement

This Capstone project will measure the student nurse's self-efficacy regarding incivility through the development and implement of an intervention (e-learning module)

using best practice guidelines aimed at educating newly admitted and second level associate degree nursing students on the definition and detection of incivility; the deleterious effects it has on the profession of nursing, on patient care and on the individuals themselves as well as provide them with ways to combat it.

Theoretical Underpinnings

Incivility, and the behaviors associated with it, are complex issues and not easily explained. Identifying why a nurse or nursing student would conscientious or subconsciously participate in the behaviors can be a difficult task. Nursing is an incredibly complex profession and continues to grow in its definition as both an art and a science; therefore one must look in many areas of educational theory to find potential answers.

Change is inevitable and as nurse educators, gatekeepers of the profession if you will, decisions must be made to define what core values we hold on to as the profession naturally evolves over time. With more and more people entering into the profession merely as a career opportunity rather than what has historically been referred to as a calling, should educators drop the art of nursing and focus solely on the science or can the profession hold on to both. Holding true to the current definition that nursing is both an art and a science, it then becomes necessary to define what desirable nursing characteristics are and have the ability to identify whether someone possesses these qualities or not, and in turn be able to provide the educational opportunities needed for them to successfully obtain and exhibit these behaviors.

Critical Social Theory and Emancipatory Knowing: Peggy Chinn

Critical social theory attempts to uncover and liberate individuals from conscience and unconscious constraints that create an unequal balance of power or participation in social interactions (Butts & Rich, 2015; Chinn, 1999; Wilson-Thomas, 1995). It further claims that people are responsible for unjustly creating social problems. Using historical societal structures that are typically based on power relationships, and cultural and political statuses environments of inequality and injustice are created.

Based on this theory schools of nursing may be guilty of fostering environments of incivility through a hierarchal mentality, and the desire to maintain social order, using the adages and assumptions like “that’s the way things are” or seeing things as “a rite of passage.” Critical social theory aims to transform this reality and liberate individuals from these constraints in order for them to participate in effective and equal social interactions (Wilson-Thomas, 1995). Fraher, Belskey, Carpenter, and Gaul (2008) an advocate for educational reform claimed that traditional education was based on conformity and cultural action for domination where students accept their educators’ values without question (Fraher et al., 2008). Critical theory allows people (nurses) the ability to challenge the traditional norms and form their own reality.

This transformation can take place through emancipatory knowing. Defined by Chinn (1999) as “the human capacity to be aware of and critically reflect on the social, cultural, and political status quo.” It holds to the belief that what people do and say ultimately affects others, claiming when human behaviors or actions harm or disadvantage others or limit human potential in any way, those actions are inherently wrong and need to be changed (Butts & Rich, 2015, Chinn, 1999). Its goal is to establish

an explicit value in the social community by remaining constantly vigilant in identifying barriers to a person's wellbeing.

Incivility creates inequality among the nursing students within the academic setting and has significant potential to cause harm to student nurses. Associated with high rates of workplace attrition, poor performance, absenteeism, accidents, decreased commitment, and low satisfaction rates; as well as medical errors (Ceravolo et al., 2012; Smith et al., 2010) students must be given the tools needed to help them combat incivility. In this classic study Wilson-Thomas (1995) claims that through the use of critical theory and emancipatory knowing students can become ethical, moral, responsible, and accountable individuals in society.

Social Cognitive Perspectives: Bandura's Learning Theory

Bandura's Social Learning Theory (1997-2001) hypothesized that human behavior can be learned through interactions with others "modeling". His original theory focused solely on the observation that people do not need to have direct experience to learn and that much of what people learn is based on observing others through role modeling and mentorship. It is now referred to as social cognitive theory and includes sociocultural factors with an emphasis on the important role self-efficacy, as a concept, has on the learner (Butts & Rich, 2012).

In a study by Goldenberg, Iwasiw, and MacMaster (1997) researchers conducted a descriptive study utilizing a pre-test/post-test design to investigate self-efficacy levels of senior level nursing students paired with a preceptor. A voluntary non-probability convenience sample of 74 students and preceptors was used, and the participants were tracked over a 12-week period of time. Seventy-four completed the self-efficacy pre-

questionnaire and 47 completed the post questionnaire, which was derived from the social learning theory by Bandura. Parametric tests were used to answer research questions and results were determined using t-tests. Results showed a significant increase in the student's self-efficacy when paired with a preceptor and recommendations were made to continue the practice. No statistical difference was shown in the preceptor's self-efficacy scores.

Bandura's theory was used as the conceptual framework for this Capstone project. Bandura's concept of self-efficacy offers a link between self-perceptions and individual actions, and focuses on the learner's perceived assessments of their abilities related to performance of specific behaviors (Goldenberg et al., 1997). This study further noted the use of Bandura's four concepts/phases (previously mentioned) as the student's likely observed their preceptors early on (Bandura's attention phase) and gradually took on more responsibility and were probably encouraged by their preceptors (Bandura's retention and reproduction phases). Performance accomplishment was suggested as Bandura's fourth concept (motivational phase) as being the greatest influence on their increased self-efficacy (Goldenberg et al., 1997).

This study is relevant to quality improvement efforts regarding incivility interventions, as it provides a theoretical framework for mentorship by nursing educators. With the implementation of interventions and an IIC module nurse educators can role model desired civil behaviors and nursing students can in turn adopt these behaviors through mere mentorship.

Work Planning

Project Proposal

A formal, written project proposal was submitted to the Capstone chair in May of 2015. A meeting was held on June 2, 2015 to present the final project proposal to the Capstone team, using personal Microsoft PowerPoint and Word programs, and printed materials, the project chair attended via telephone conference. All members agreed upon current project direction and the Capstone was officially approved. The implementation site's program director was presented the approved Capstone project proposal in a separate meeting the same day and gave formal verbal and written approval to implement the Capstone project on their site.

Project Management Tools

Two qualified individuals with extensive experience in nursing education have been chosen to be part of the Capstone team. Both individuals work with the target population of associate degree nursing (ADN) students and are employed at the site of implementation. Both team members have contributed significantly to the needs assessment portion of the project. Team members suggested a survey to be conducted and given to the graduating class of nursing students to determine if students thought an incivility intervention was needed in their educational training (97% of student's polled agreed an intervention was needed). Capstone team members also suggested the use of a tool in order to determine a student's awareness when they are contributing to incivility.

Personally licensed Microsoft PowerPoint, Word, and iSpring software was utilized to develop the e-Learning module. Although the Capstone team was consulted

and included on the content of the e-learning module, solely the project leader compiled the module itself.

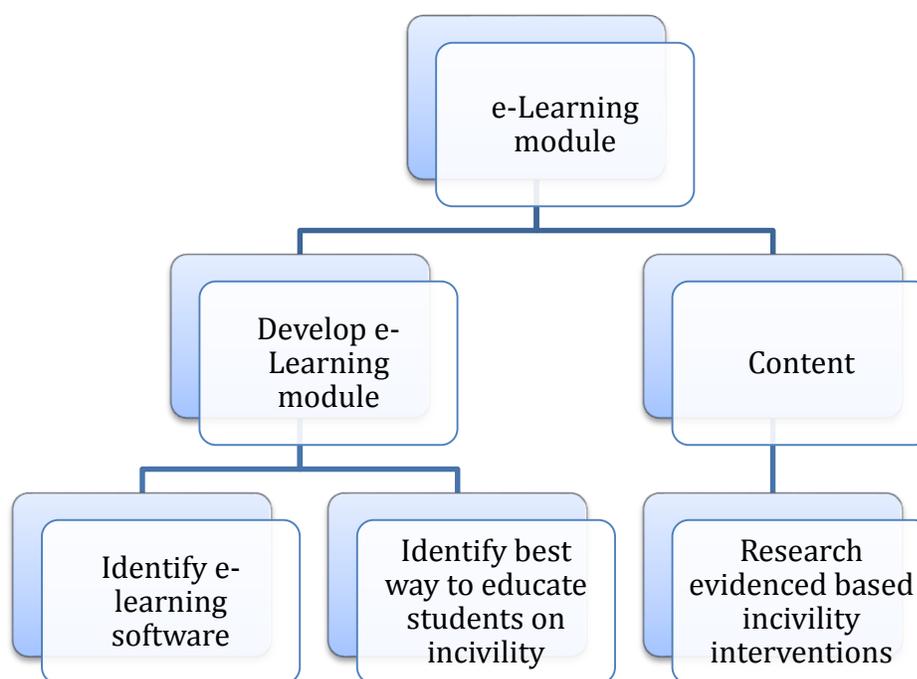


Figure 1. Work Breakdown and Milestones

It is imperative to find the correct platform in which to provide the nursing students with the incivility interventions. Several ideas were considered by the team, a face to face educational lecture with student participation in scenarios, developing and having the students participate in a case study regarding incivility and having them come up with potential interventions. It was ultimately agreed that the students needed to be provided the evidenced based interventions versus coming up with them on their own which may lead to disagreements or confusion. It was deemed more appropriate to

develop a freestanding and consistent e-Learning module that can be utilized every year providing the students with accurate information.

Once an e-Learning module was agreed upon finding the software that had the capabilities to incorporate video, audio and visual aids as well as a pre and posttest was the next step. The Capstone team then identified the best interventions to incorporate into the e-Learning module. Development of the e-Learning module was the final step prior to implementation of the finalized e-Learning module in October of 2015.

Budget

The entirety of the preparatory work for Capstone project was conducted outside the implementation site; therefore no cost was ensued by the institution itself. Capstone team members agreed to work on the Capstone project outside of their normal work hours and all work is voluntary, no compensation is given for participation. The only accrued cost is the purchase of the e-Learning software iSpring was \$100.00 and was paid by the DNP student.

Institutional Review Board Process

The implementation site did not have an Internal Review Board (IRB) and therefore a consent form is not required. Consent to implement the project at the implementation site was obtained from the program's director and was provided to the University's school of nursing per DNP-program requirement. An IRB application was submitted to DNP student's University per procedure and requirement and a letter of acceptance was received on October 15, 2015.

Evaluation Planning

Evaluation of the project consisted of qualitative data collected during the implementation phase of the Capstone project. Using Bandura's platform of increased self-efficacy a pre-test/post-test was embedded into the e-Learning module. Collecting data regarding whether the student found the information useful (increased self-efficacy) and also if the student feels they will use the interventions within the academic settings including, but not limited to clinical rotation sites.

This data was added to the previously collected survey results gathered during the needs assessment portion of the Capstone project. Expectantly, the responses validated the continued use of the e-Learning module. Showing long-term quality improvement through the anticipated increase in student civility and the ability/self-efficacy to thwart incivility directed at them. Optimistically the e-Learning module will become a part of the curriculum for future nursing students as well as being implemented into other schools of nursing.

Implementation

The project implementation began on October 28th, 2015 and ended on November 17th, 2015. The e-learning module was uploaded onto the community colleges' Blackboard (a virtual learning environment and online course management system) account. The module was made available to all 154 first and second level students. The students' were sent an initial e-mail on October 27th, 2015 making them aware of the e-learning opportunity and desired participation. Second and third reminder e-mails were sent to the students on November 4th and 11th, 2015 to encourage continued participation.

On November 17th, 2015 the e-learning module was removed from Blackboard, a total of 110 students completed the e-learning module for a 71% response rate.

Interpretation of the Data

Outcomes

After the online e-learning module was completed, data was collected in the form of e-mails containing module quiz results set up using a feature in the iSpring software. A total of nine quizzes were embedded into the e-learning module. A pre-test and post-test (see Table 1) were given to acquire the student's level of self-efficacy before and after completing the e-learning module. Module three's quiz was the Clark Civility Index for Students© (see Table 4), used with written permission. The index is an evidence-based survey designed to assist in awareness, generate discussion, and to help gain insight into incivility. The index was used in this e-learning module as anecdotal information to gage the nursing student's self-perception of their potential to engage in uncivil acts. There were also three individual module quizzes (see Tables 2, 3, & 5), with module four containing four video scenarios with each scenario containing an individual quiz (see Table 5).

For each of the nine quizzes there were 104 e-mails containing results, totaling 936 e-mails. The e-mails were separated into individual folders, each folder containing its own module quiz results. To ensure accuracy of the data the researcher compiled the data results using a self-developed template using Microsoft Word to tally the individual results; the results were then shared with a co-team member who provided a second check for correctness.

The pre-test/post-test results were of greatest interest and a statistical analysis of the results was conducted (see Table 1). The results showed a significant increase in the student's self-efficacy regarding the ability to identify and respond appropriately to incivility after completion of the e-learning module (see Table 1). Since the survey responses were polytomous, a nonparametric test was a good option, therefore the McNemar statistical test was utilized. The McNemar test is a nonparametric test that evaluates whether there is a statistically significant difference in proportions for 2x2 contingency tables (Laerd Statistics, 2013, Mertler & Vannatta, 2013). The McNemar test is often used to analyze pretest-posttest study designs when there are dichotomous responses such as what was used in the e-learning module (Laerd Statistics, 2013, Mertler & Vannatta, 2013).

The three individual module quizzes were graded on a pass/fail interpretation, if students answered all questions correctly this resulting in a passing grade, anything other than 100% correctness resulted in a failing grade. Results were as follows for modules one and two, 82% of students passed module one's quiz (see Table 2); 95% of students passed module two's quiz (see Table 3). Module four consisted of the four video scenarios with coinciding quizzes, 80% of students passed module four-scenario one's quiz; 72% of students passed module four-scenario two's quiz; 66% of students passed module four-scenario three's quiz; and 96% of students passed module four-scenario four's quiz (see Table 5).

Although statistical analysis was not used for the individual module quizzes, the pass/fail results were very promising with the majority of students passing each module (see Tables 2, 3, & 5). The high passing rate suggested the students were engaged in the

content with each module, paying attention, and comprehending the information. Module one and two's questions were based upon comprehension of the material presented, however, module four's questions correlated to the video scenarios and required application of the knowledge. With the majority of students' passing these quizzes, there is further evidence of the e-learning modules' effectiveness in meeting its goals. The results seem to show the students had a more difficult time answering the questions pertaining to the video modules (see Table 5). This may be due to the necessity to apply the knowledge they had previously learned to the video scenarios versus the previous modules where students' read the information and were asked a knowledge-based question pertaining to the material immediately afterwards. It seems the question associated with video scenario three pertaining to confronting someone who displayed uncivil behaviors' proved to be especially difficult for the students (see Table 5). This result correlates to findings within the data from Clark's Civility Scale (questions 11 & 13) that suggested students are less likely to engage in confrontation when others display uncivil behaviors (see Table 4).

The information gleaned from the Clark's Civility Scale rendered interesting results. The scale was used for this project in an attempt to get student's to think about their own involvement in uncivil behaviors, however, the results appeared to show that the students rarely admitted to engaging in uncivil acts (see Table 4). The students answered the majority of the questions with, always and usually when questioned if they engaged in appropriate civil behaviors. When looking closer at the responses however, it seems there are a few patterns of civil and uncivil behaviors emerging. Question 11, for example, shows almost all students answering they avoid taking credit for someone else's

work, suggesting this may be seen as taboo amongst nursing students or perhaps being in the academic realm the students are thinking more along the lines of the ramifications of plagiarism and therefore know not to participate in this behavior. Another anomaly is shown on questions four and five; the results suggested that more students admitted to the uncivil acts of making sarcastic remarks and gestures and that they participated in gossip or the spreading of rumors. Questions 11 and 13 dealt with the student's ability to address or confront others who were displaying uncivil behaviors and the results suggested students seemed less willing or capable to do so. Even though the majority of students claimed to display civil behaviors most of the time, the results of the civility scale showed students were still engaging in acts of incivility. These results provided additional evidence that students may benefit from the education provided in the e-learning module regarding their ability to define, detect and combat academic incivility.

The statistical analysis of the pre-test/post-test was highly encouraging, showing statistical significance that the students obtained a higher degree of self-efficacy regarding their ability to define, detect, and combat incivility. With the detrimental effects the students can endure at the hands of incivility, it is with great satisfaction the e-learning module has shown to be an effective way to help the student's deal with this latent phenomenon. (Tables 1-5)

Table 1

Student Nurse's Perceived Self-Efficacy Pre and Post-Test

Questions	Pre-Test & Post- Test N= 110								P-Value
	Very Familiar		Familiar		Somewhat Familiar		Not Familiar		
	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	
What is your familiarity of academic civility?	N=10	N=91	N=56	N=19	N=9	N=0	N=35	N=0	$p < 0.05$
How confident are you that you can identify multiple forms of academic incivility?	Very Confident		Confident		Somewhat Confident		Not Confident		$p < 0.05$
	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	
	N=11	N=87	N=52	N=23	N=6	N=0	N=41	N=0	
When faced with academic incivility how confident are you that you can respond appropriately and effectively?	Very Confident		Confident		Somewhat Confident		Not Confident		$p < 0.05$
	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	
	N=13	N=60	N=58	N=50	N=2	N=0	N=37	N=0	
I believe academic incivility is a serious problem in nursing?	Strongly Agree		Agree		Disagree		Strongly Disagree		$p < 0.05$
	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	
	N=13	N=66	N=66	N=44	N=6	N=0	N=25	N=0	
I believe I can make a difference in stopping academic incivility?	Strongly Agree		Agree		Disagree		Strongly Disagree		$p < 0.05$
	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	<i>Pre</i>	<i>Post</i>	
	N=19	N=69	N=80	N=41	N=5	N=0	N=6	N=0	

Note. Question #1. Success = familiar and very familiar; Failure = not familiar and somewhat familiar
 Question #2 and #3. Success = confident and very confident; Failure = not confident and somewhat confident.
 Question #4 and #5. Success = agree and strongly agree; Failure=disagree and strongly disagree
 Overall Conclusion. There is enough evidence to conclude that the proportion of successful responses for the pretest is different from the proportion for the posttest for questions 1-5 after watching the e-learning module. Therefore, we can conclude that the e-learning module had a significant effect on the responses on all five questions of the survey.

Table 2

Modules 1 Assessment Questions

Module Questions	Pass/ Fail N= 110	
1. Do student nurses have the ethical responsibility to uphold professional standards like the ANA's Code of Ethics? Yes/No	Pass	Fail
2. Nurses who are victims or witnesses incivility will likely become accepting of uncivil behaviors or become perpetrator themselves. True/False	N=91	N=19
3. What percentages of new graduate nurses are leaving their first jobs due to incivility? A. 20% B. 30% C. 50% D. 60%		

Note. Table 2 represents students who passed or failed the individual module quizzes. Module 1 Quiz: 82% passed.

Table 3

Modules 2 Assessment Questions

Modules Questions	Pass/ Fail N= 110	
As a student it is not my responsibility to report witnessed acts of incivility? Yes/No	Pass	Fail
Actions not taken can be considered acts of incivility? True/False		
People aren't affected by incivility unless it occurs face-to-face. True/False		
Which behaviors are considered uncivil? . Gossiping . Name calling . Refusing to assist a colleague . Eye Rolling . All of the Above	N=104	N=6

Note. Table 3 represents students who passed or failed the individual module quizzes. Module 2 Quiz: 95% passed.

Table 4

Module 3 Clark's Civility Index

Questions	N=110				
	ALWAYS	USUALLY	SOMETIMES	RARELY	NEVER
1. Role model civility, professionalism, and respectful discourse	56	50	4	0	0
2. Add value and meaning to the educational experience	51	52	7	0	0
3. Communicate respectfully (by e-mail, telephone, face-to-face) and really listen—	71	33	6	0	0
4. Avoid gossip and spreading rumors	60	36	13	1	0
5. Avoid making sarcastic remarks or gestures (staged yawning, eye-rolling)	58	39	13	0	0
6. Pay attention and participate in class discussion and activities	66	35	7	2	0
7. Use respectful language (avoid racial, ethnic, sexual, gender, religiously biased terms)	87	20	2	1	0
8. Avoid distracting others (misusing media, devices, side conversations) during class	65	40	4	1	0
9. Avoid taking credit for someone else's work or contributions	100	8	1	1	0
10. Co-create and abide by classroom and clinical norms	84	25	1	0	0
11. Address disruptive student behaviors and promote a safe, civil learning environment	56	26	23	5	0
12. Take personal responsibility and stand accountable for my actions	95	14	1	0	0
13. Speak directly to the person with whom I have an issue	53	41	15	1	0
14. Complete my assignments on time and do my share of the work	93	16	1	0	0
15. Arrive to class on time and stay for the duration	87	21	1	1	0
16. Avoid demanding make-up exams, extensions, grade changes, or other special favors	79	29	2	0	0
17. Uphold the vision, mission, and values of my organization	92	17	1	0	0
18. Listen to and seek constructive feedback from others	81	28	1	0	0
19. Demonstrate an openness to other points of view	76	32	2	0	0
20. Apologize and mean it when the situation calls for it	89	20	1	0	0

Table 5

Modules 4 (1-4) Questions for Individual Video Scenarios

Scenarios 1 - 4	Pass/Fail N=110	
Module 4 Scenario 1	Pass	Fail
1. Interrupting class is a form of academic incivility. True/False		
2. Do you believe this situation warrants an intervention? Yes/No		
3. Who do you think should have a respectful conversation with John? One of his fellow Students/Instructor	N=88	N=22
4. Validate the facts (choose only the facts).		
A. Traffic was terrible.		
B. John was late for class.		
C. John asked another student a question during lecture.		
D. The student next to John was angry.		
Module 4 Scenario 2	Pass	Fail
1. How would you show Tom empathy during the respectful conversation?		
A. Make sure Tom understands his actions were unacceptable.		
B. Repeat the situation and give specific details.	N=80	N=30
C. Truly listen to Tom's point of view.		
D. Report the interaction to the administrator.		
E.		
Module 4 Scenario 3	Pass	Fail
1. How would you deliver the message that you thought the interaction was uncivil?		
A. Immediately during report so it doesn't happen again and the nurse knows where you stand.		
B. Ask to speak to the nurse in private right away; you can't spend your day upset.	N=73	N=37
C. Wait for a little while and reflect on the situation and then ask the nurse to speak privately if you determine it warrants an intervention.		
Module 4 Scenario 4	Pass	Fail
1. The student's decision to go ahead and complete the work without the third group member can be considered inaction and is a form of incivility. True/False		
2. Working in groups is an important skill and one student's need to develop in nursing school? True/False	N=106	N=4

Note. Table 5 represents students who passed or failed the individual module quizzes Scenario1: 80% passed. Scenario 2: 72% passed. Scenario 3:66% passed, and Scenario 4: (96% of students passed.

Achievements

This was the first time an e-learning module was successfully implemented in the ADN program at this particular community college. The directors of both the ADN and practical nursing (PN) degree programs at the implementation site have expressed their interest in the continued use of the e-learning module as a part of the curriculum and asked for permission to use it as one of the schools strategic planning and retention initiatives. There has also been interest, in the form of informal conversations with local nursing educators, for the use of the module at the local hospital for an educational component of nursing mentor orientation and at the local south eastern health education center (SEHEC) to potentially set up the module for continued education credit.

Recommendations for Improvements

The e-learning module contained video scenarios; these scenarios could be made more generalized in its content to better help students recognize more varied forms of incivility rather than a few specific cases. The number of quizzes could be replaced with a single cumulative test at the end of the e-learning module. By testing at the end, one could possibly obtain information regarding content mastery rather than brief quizzes at the end of each module, which may not show a true understanding but rather an ability to memorize information for a short period of time. Another recommendation would be for students to sign a contractual agreement to act in a civilized manner and follow the chain of command for reporting acts of incivility.

Plan for Sustainability

The implementation site has stated interest in continuing the use of the incivility e-learning module on an annual basis to be given to incoming freshman ADN and PN

students. Next steps would include obtainment of a copyright for the e-learning module and dissemination to interested schools of nursing. It is with optimism that schools of nursing will be interested in and adopt into their programs the ready-made educational e-learning module with evidence-based content and statistically significant results.

Utilization and Reporting of Results

The e-learning module and the results were met with enthusiasm at the implementation site. Outcomes from the employment of the e-learning module will be presented on the project leader's DNP presentation day and will be uploaded into ProQuest. Future presentations may include poster or podium presentations as well as potential manuscript submissions.

Conclusion

Incivility is an unfortunate factor in nursing and it appears to have its grip on the newest and arguably most instrumental members of the profession. Without proper education on ways to identify and appropriately respond to incivility, nursing students are at risk for long lasting complications that can inevitably affect the students' nursing careers. Schools of nursing should be implored to take responsibility and include incivility education in their nursing programs. The incivility e-learning module can serve as a model and a template for schools of nursing to help provide effective education and help in the eradication of academic incivility for the future generation of nurses.

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